Health Care

Issue

Spouses expressed interest in gaining information about local health care policies, transferring their Prime benefit, and health care services available to them including details on the civilian provider network, claims processing phone numbers and the location of TRICARE Service Centers. Spouses suggested participating in their sponsor's in-processing at new duty assignments.

Background

The Office of Customer Service and Beneficiary Education was created to assume primary responsibility for the customer service activities and beneficiary education communications of the TRICARE program. The staff manages and/or designs the production of a wide range of informational material used to assess customer attitudes and communication needs and develop Ombudsman strategies, activities and materials.

"One of the biggest problems is that the family members do not know what TRICARE is supposed to do for them or how to get service when its needed."

—Air Force Chief Master Sergeant Renee Chapman

Current Status

The Medical-Personnel Issues Forum, an initiative begun in June 1999, is currently working on the issue of health care information being readily available to newly arriving personnel. Working groups are looking at ways to ensure that complete and uniform local TRICARE information is offered during in-processing, and at other times, at all military installations worldwide.

Current Initiatives

Beneficiary Counseling and Assistance Coordinators (BCACs). The establishment of these positions at Lead Agent offices and at all military hospitals was mandated in the FY00 Authorization Act. Formerly known as Health Benefits Advisors, Ombudsmen, Patient Advocates, and other customer service titles, the BCAC serves as the beneficiary advocate and problem-solver, responding to phone, written, and verbal concerns and questions from our beneficiaries. BCACs troubleshoot complicated, delayed, or mishandled problems between the beneficiary, TRICARE Service Centers, Managed Care Support Contractors, or the TRICARE Management Activity (TMA). We are developing a tracking/trending mechanism to better serve our beneficiaries, provide management information for decision makers, and to provide "early warning" on adverse trends in beneficiary feedback. The worldwide BCAC Directory was posted on our TMA Web site in June 2000.

Debt Collection Assistance Officers (DCAOs). DCAOs will assist service members in solving outstanding medical bills. Billing errors and payment misunderstandings have resulted in some service members receiving notices from collection agencies and bad credit ratings. DCAOs can intercede with all agencies involved, including military personnel offices, military hospitals and clinics, lead agents, network providers,

TRICARE Management Activity (TMA), and managed care support contractors. Once contacted by a beneficiary, DCAOs have authority to research cases and bring them to conclusion. DCAOs are available at all military hospitals and clinics and at TRICARE lead agent offices. A DCAO directory can be found on the Military Health System/TRICARE Web site at ***http://www.tricare.osd.mil/dcao/***.

Sources for further information. Helpful information and all current policies are available on the TRICARE Web site at ***www.TRICARE.osd.mil***. Other helpful sources include Beneficiary Counseling and Assistance Coordinators (BCACs) at Lead Agent offices and all military hospitals, and TRICARE Service Centers.

Issue

TRICARE network providers limit the number of patients they see and leave the TRICARE program because of insufficient compensation and untimely reimbursement. A letter should be sent to those providers whose participation has expired, detailing program improvement, particularly with respect to authorized payment procedures.

Background

Provider participation in TRICARE is affected by claims processing, reimbursement rates, and network adequacy. Many providers have expressed concern over slow claims processing, which involves the accurate and appropriate settlement of health care bills based upon the rules, policies and requirements of DoD. Some providers are concerned about the reimbursement rates in TRICARE. Congress directed DoD to adopt or adapt Medicare payment approaches when appropriate. DoD's network adequacy requirements are based on California's Knox-Keene Act, which provides guidelines for health maintenance organizations (HMOs) on numerous aspects of access-to-care, including network adequacy ratios and the amount of time it takes to drive to a provider's office. In addition to these standards, most of DoD's managed care support contractors (MCSC) elected to use more stringent guidelines for certain types of specialty care.

Current Status

TRICARE claims processing is complex due to factors such as numerous eligibility categories; different cost-shares, deductibles, and benefits based on these categories; three distinct programs (Prime, Extra and Standard) with different processing requirements; and more.

In adapting Medicare's payment approaches to TRICARE, it has been vital to recognize the differences in the programs and the populations they serve, and to accommodate those differences in the payment process. For some providers, there is no Medicare coverage, and in these cases DoD has developed its own reasonable, cost-effective reimbursement approaches. A key principle of DoD's reimbursement reform has been the protection of beneficiary access to care.

While the overall network appears to be adequate, we know there are some deficiencies in rural areas, particularly areas considered medically under-served and those with few managed care networks. These conditions are not unique to TRICARE. Our MCSCs have addressed network adequacy issues through various means, such as bringing in non-local providers on a temporary basis or negotiating with non-contracted providers to accept TRICARE payment.

The TRICARE civilian network, like other provider networks, experiences providers joining and leaving on a fairly continual basis. The reasons are numerous and do not always represent dissatisfaction with the network or TRICARE.

Regarding the recommendation to send letters to providers whose participation has expired, the Provider Relations Department at each MCSC communicates with and assists any provider considering joining or returning to the TRICARE network.

Current Initiatives

The TRICARE Management Activity, along with DoD's Managed Care Support Contractors (MCSCs), developed a Claim Processing Enhancement Plan. Current initiatives under the Plan will address improvements in provider authorization procedures, obtaining additional claims information, claims processing timeliness standards, utilization management reviews, and processing third-party liability claims.

We are working to implement a proposal that would allow the Secretary of Defense to authorize higher provider payments than normally allowable, when it is necessary to ensure an adequate TRICARE Prime network of qualified providers. Additional actions being considered that would be taken when TRICARE beneficiaries face very severe limitations on access to needed health care services, include authorizing higher TRICARE payments than would normally be allowable for professional services in a designated location.

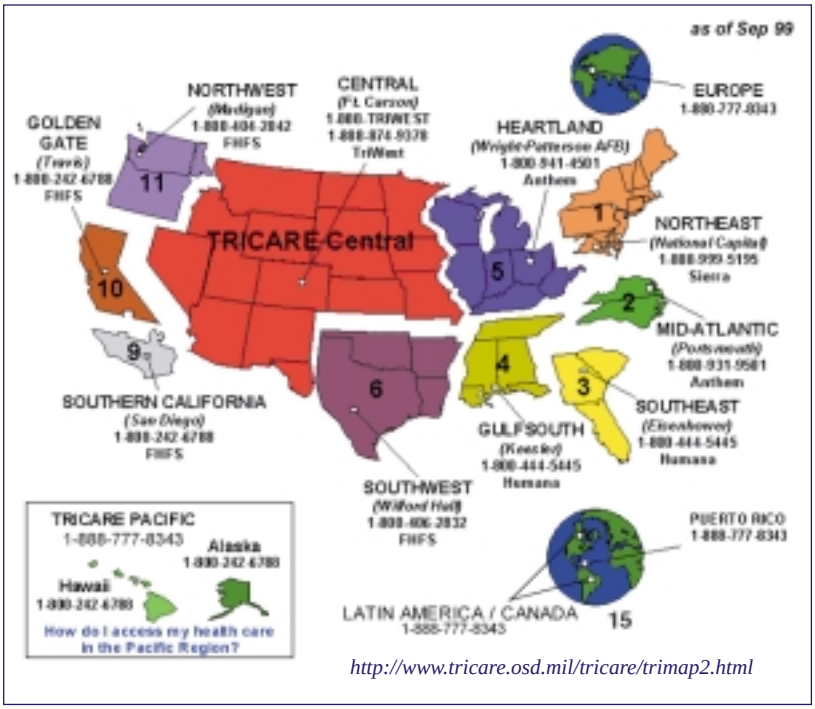
The TRICARE Prime Remote program began last year for active duty members. This new TRICARE initiative allows servicemembers who are assigned significant distances from a military hospital to receive care in their local area. We have asked the Congress for authority to extend this program to the families of our active duty personnel assigned to remote or distant locations. We expect that the authority will be granted this year and we will extend the program shortly thereafter.

Issue

There needs to be greater consistency of TRICARE service across the regions. Standardized procedures would assist beneficiaries in obtaining needed health care when they are temporarily out of their home region for such reasons as temporary duty, leave, or children attending college.

Background

The TRICARE benefit, that is the services covered and cost shares involved, remains identical across the country. Differences in administration are found from region to region, and this arises from an emphasis on individual patient needs within the framework of a cost-effective managed care program. When going to a new region, even temporarily, beneficiaries should contact the Beneficiary Counseling and Assistance Coordinator (BCAC) in the Lead Agents Office or in the military hospital in the new region to determine how best to meet their health care needs under differing Regional guidelines.



http://www.tricare.osd.mil/tricare/trimap2.html

Current Status

Managed Care Support Contractors (MCSC) set criteria for pre-authorization of particular services within their region based on treatment patterns in that area. Lead Agents may establish particular administrative approaches based on their knowledge of the local health care environment. The Lead Agent concept is based on having health care decisions made on a local level, taking into account the uniqueness of each region. Allowing this variation in administration ensures that physicians, following appropriate medical criteria, determine treatment received by patients, rather than having treatment options constrained by rigid, program-wide controls.

Current Initiatives

Portability of Benefits across Regions. In January 2001, the MCSC for TRICARE will become responsible for enrollment of TRICARE beneficiaries, including Active Duty personnel. At present, military hospitals have this responsibility.

The TRICARE Service Centers (TSCs) will collect enrollment applications for those assigned within their service area during a sponsor's in-processing. The MCSC will compare the information on the application with the information in DEERS. Provided the information is consistent and the beneficiary is eligible, the contractor will initiate the enrollment process.

Having the MCSC responsible for enrollment will provide a more centralized, streamlined, and universal process, thus producing a more continuous and consistent benefit. The success of this approach will depend on updated information being provided to the MCSCs as soon as a change takes place for any beneficiary. All beneficiaries can assist this process by ensuring that their information in DEERS is accurate and by updating that information as soon as their information changes.

MCSCs will use a standardized, universal enrollment form for all TRICARE Prime enrollees. A standardized TRICARE Prime enrollment card will be issued to each Prime enrollee. This card will contain a Region-specific 1-800 number for enrollees to call the MCSC with any health care questions or needs.

Primary Care Manager Assignment. Although the new enrollment card will not have pre-printed Primary Care Managers (PCM) names on them when sent to beneficiaries, beneficiaries will receive letters from military hospitals or Managed Care Support Contractors indicating the names of their PCMs. The card will contain erasable fields for the PCM name and telephone number, so the beneficiary can fill it in and make changes as necessary.

Issue

When a military family needs emergency care, it should be available right away without administrative delays.

> ***"Consumers have the right to access emergency health care services when and where the need arises."***
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> ***—Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry***

Background

In March 1997, President Clinton appointed the Advisory Commission on Consumer Protection and Quality in the health care industry. He charged this Commission to advise "on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system." As part of its work, the President asked the Commission to draft a "consumer bill of rights."

Current Status

In its report, the Commission stated that, "Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a 'prudent layperson' could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." Emphasis is placed on the patient's presenting symptoms rather than the final diagnosis.

Current Initiatives

TRICARE's policy encompasses the Commission's recommendations and the "prudent layperson" standard. Under TRICARE, emergency department care is covered for medical, maternity, or psychiatric emergencies that would lead a "prudent layperson" (someone with average knowledge of health and medicine), to believe that:

a. A serious medical condition exists, or
b. The absence of medical attention would result in a threat to his/her life, limb, or sight and requires immediate medical treatment, or
c. The patient is experiencing severe pain and needs immediate relief.

Additionally, TRICARE's policy states that claims must be processed based on the patient's presenting symptoms rather than the discharge diagnosis. The policy also contains a provision that the Managed Care Support Contractor shall not retrospectively deny claims because a condition which appeared to be a serious medical condition when presenting to the emergency department turned out to be non-emergency based on the final diagnosis. In other words, claims shall not be denied in situations where the beneficiary presents to the emergency department with a condition that would cause a prudent layperson to believe an emergency exists, but the final diagnosis is determined to be a non-emergency condition. A common example of this is when a beneficiary seeks treatment for chest pain, but the final diagnosis is indigestion.

Emergency department services do not require pre-authorization. A denied claim for emergency department care is an appealable issue.

We have implemented the prudent layperson standard in all TRICARE Regions in the U.S. except in Region 1. In Region 1, all emergency department claims will be paid while implementation of the prudent layperson standard is pending.